Ontario County Annual CHIP Report

March 14

2019

The Annual CHIP Report documents progress made in 2018 on the implementation of the 2016-2018 CHIP. The purpose of the report is to determine if our combined efforts have had a positive effect on the health of our community; if our process measures have been met; if there are strategies that should be set aside or added; and if partners are able to continue their work.

Compiled by
Kate Ott, MPH

ONTARIO COUNTY HEALTH COLLABORATIVE
ANNUAL CHIP REPORT, 2018

Introduction

The original 2016-2018 Community Health Improvement Plan (CHIP) was written by members of the Ontario County Health Collaborative (OCHC) after completion of a community-wide assessment in 2016. Since then, updates have been made periodically in response to:

- Addition of new partners and stakeholders;
- Receipt of NYS Chronic Disease Incentive Funds (2017-18);
- Emerging issues in Ontario County (opioids and suicide); and
- Loss of feasibility for some programming due to loss of partnerships or funding streams.

The disparate group addressed throughout the CHIP (low socioeconomic status) remains unchanged.

2016-2018 CHIP Priority and Focus Areas

- **Priority Area 1:** Prevent Chronic Diseases
  - *Focus Area 1:* Reduce Obesity in Children and Adults
  - *Focus Area 2:* Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure
  - *Focus Area 3:* Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings
- **Priority Area 4:** Promote Mental Health and Prevent Substance Abuse
  - *Focus Area 2:* Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders

Timing

This year, 2019, is a Community Health Assessment year. Though our current CHIP is dated 2016-2018, we will continue to use and fine tune it throughout 2019. A new CHIP (2019-21) will be developed by the OCHC during the summer and fall of 2019. It will be implemented in 2020 after approval is received from the New York State Department of Health.

Purpose of the 2018 Annual CHIP Report

The purpose of this report is to determine if our combined efforts toward defined goals and objectives have been effective and continue to be feasible.

- Has our work had a positive effect on the health and/or safety of our community?
- Did we meet our process measures?
- Do we need to revise, replace or remove any strategies?
- Do we need to add or develop new interventions due to emerging issues?
- Can partners continue their work?

How to Review the Report

This document is divided into Priority Areas, Focus Areas and Goals. Interventions, Partners and Process Measures are noted for each goal. Whenever possible, the author has provided new

data related to the NYS Prevention Agenda's Overarching Objectives. It is important for the reader to review progress on Process Measures, as well. These are highlighted in yellow. Areas in which progress was not seen are highlighted in gray. Blue boxes throughout the document include strengths, challenges and in some cases, changing priorities related to strategies and interventions.

Thank you for your partnership throughout 2018 and for making Ontario County a healthier, safer place in which to live, work and play.

The Ontario County Health Collaborative

ONTARIO COUNTY HEALTH COLLABORATIVE
ANNUAL CHIP REPORT, 2018

PRIORITY AREA: PREVENT CHRONIC DISEASE

FOCUS AREA 1: REDUCE OBESITY IN CHILDREN AND ADULTS

GOAL 1.1 CREATE COMMUNITY ENVIRONMENTS THAT PROMOTE AND SUPPORT HEALTHY FOOD AND BEVERAGE CHOICES AND PHYSICAL ACTIVITY

Overarching Objective 1.0.1

Overarching Objective A: By December 31, 2018, reduce the percentage of children who are obese by 5% from 13.1% (2010) to 12.4% among WIC children (ages 2-4 years). (Data Source: NYS Pediatric and Pregnancy Nutrition Surveillance System [PedNSS])
13.1-12.4/13.1x100=5% change

Error in Objective A: NY State Children Obesity Rate

- The 2010 rate of 13.1% applies to children <5, not children ages 2-4
- In 2010, 14.5 children were obese in the age range of 2-4 years

RESULT

Obesity Rate among WIC Children*	NY State % Decrease 2010-17	Ontario County % Decrease 2012-17
< 5 year-olds	20.6%	8.9%
2-4 year-olds	4.1%	4.4%

*See obesity rates in histograms pages 6-7
Source: Pediatric and Pregnancy Nutrition Surveillance System

Overarching Objective B: By December 31, 2018, reduce the percentage of children who are obese by 5% from 17.6% (2010-12) to 16.7% among public school children Statewide reported to the Student Weight Status Category Reporting system (Data Source: NYS Student Weight Status Category Reporting [SWSCR]) (Prevention Agenda [PA] Tracking Indicator)

RESULT

Statewide Student Weight Status*	NY State % Obese	Ontario County % Obese
2010-2012	17.6%	16.1%
2016-2018	16.5%	16.7%

*See histograms pages 6-7
Source: Pediatric and Pregnancy Nutrition Surveillance System
NY State saw 6.3% decrease and Ontario County a 3.4% increase.

Interventions, Strategies and Activities

1. Implementation of evidence based programs including:
    a. "Get Up Fuel Up" and "Food, Fun, and Fitness"
    Partners: UR Thompson Health; OCPH and OCHC – Promotion and Networking

b. CHAT, Food, Fun, and Fitness program
Partners: Finger Lakes Health (FLH); OCPH and OCHC – Promotion and Networking
D/C 12/2017 due to lack of funding
c. Rethink Your Drink
Partner: FL Eat Smart NY /Cornell Cooperative Extension

2. Provide food demos, classroom based lessons, afterschool workshops, presentations at school assemblies and fairs and family and parent events. Partners: FL Eat Smart NY, UR Thompson Health, Finger Lakes Health, Rochester Regional Health (CSHC) , Ontario County Public Health.

3. Assist schools in high need communities in implementing policies, systems, and practices that improve access to nutrition education, healthy foods, and physical activity.

Partners on these three strategies:

- UR Thompson Health
- Finger Lakes Eat Smart NY/Cornell Cooperative Extension (FLESNY)
- Ontario County Public Health (OCPH)
- Finger Lakes WIC
- Finger Lakes Community College (FLCC)
- Finger Lakes Health (FLH)

Process Measures: Number of programs/ presentations offered, number of participants, participant feedback

UR Thompson Health

- 12 programs
  - *Get UP!FuelUp!*, *Eat Your Colors* and Summer Camp Nutrition Education
- 1,600 pre-school and school-aged children reached
- Post intervention surveys positive

FLESY

- 197 educational opportunities throughout year including *Rethink Your Drink* campaign
- 3 programs: school-based CATCH, Cooking Matters and Seed to Supper
- 2,197 OC residents reached
- Post intervention surveys were positive

Finger Lakes WIC

- 20-28 Clinics a quarter at which nutrition education was provided

Finger Lakes Health

- *Cubby Chase*, family fitness event
- *Get Ready to Run* community exercise and healthy eating program
  - 42 participants
- *Thrive to Strive* nutrition education for cancer survivors

Strategies 1-3
Strengths:
+ Partnering with schools provides access to large audiences.
+ Working with children instills healthy life-long behaviors.
+ Community events that provide exercise and nutrition education utilizing social support in the community are recognized and recommended by the Community Preventive Services Task Force (CPSTF).

Challenges:
− The impact of childhood programming is difficult to measure, directly.
− Programming is limited to school districts able/willing to engage.
− Some partners are limited to working with populations of low SES, only, per funders.

4. Develop a Food Pantry Program to provide education, food demos, reinforcements and outreach to individuals who utilize emergency food services (Added 1/2017).

Partners
- OCPH
- FLESNY/CCE
- WIC
- FLCC

Process Measures
a. Number of food pantries involved-2
   i. Center of Concern
   ii. Salvation Army, Geneva site
b. Number of participants receiving education re healthy eating-499 reaches (by monthly attendance)

5. Pilot a County-wide initiative; *Nourish Your Neighbor* (Added 2/2018)

Partners
- OCPH
- FLESNY/CCE
- WIC
- FLCC
- United Way
- Food Pantries
- Scouts, BSA
- Media

Process Measures
a. Number of participating food pantries=9
b. Percent increases in healthy items donated at Boy Scout food drive
   i. All healthy items increased
c. Post intervention surveys show increased healthy foods donated, satisfaction with process and desire to participate in 2019

Strategies 4 and 5
Strengths:
+ Partnering with food pantries addresses SES disparity.
+ Scouts, BSA and United Way are two of the largest food donation organizations in the Finger Lakes. Partnering with them will influence nearly all of the food pantries in Ontario County.
+ Community-wide social/health marketing campaigns reach many audiences.
+ Ontario County received $48,000 (Chronic Disease Incentive Award) to be used in 2018. Most of this was used on the NYN initiative.
+ FLESNY designated funds to the NYN initiative.

Challenges:
- The impact of social/health marketing campaigns is difficult to measure.
- Sustainability without award money in future years.

Changing priorities:
The food pantry program was developed in 2017 because stakeholders felt the previous intervention (restaurant initiative) did not adequately target those of low SES. Two food pantries participated and process measures were met. In 2018, the group decided to seek out relationships with other food pantries, expand the target population and take a community-wide approach. NYN grew out of these changes in priorities.

6. Incentivize WIC clients to purchase fruits and vegetables at farmer's markets (Added 6/2/17)

Partners
- Finger Lakes WIC

Process Measures – unable to assess 3/6/19
a. Number of farmer's markets sites visited by WIC Mobile Clinic-2
b. Number of WIC Farmer's Market checks distributed-not reported
c. Number of WIC Farmer's Market checks utilized-not reported

Strategy 6
Strengths:
+ Partnering with WIC addresses the SES disparity in Ontario County.
+ Providing Farmer's Market vouchers on site should increase likelihood of use.

Challenges:
- Staffing at WIC changed mid-2018 and it was not possible to meet process measures regarding checks distributed and utilized.

7. Provide fresh fruits and vegetables to residents of low SES (Added 10/12/17)

Partners
- Food Justice of Geneva NY, Inc.
- Ontario County Public Health
- Food Pantries

Process Measures: Pounds of produce gleaned and number of sites to which food is distributed.
- Gleaned 30,000 lbs. of fruits and vegetables (36% increase from 2017)
- Distributed to 30 sites

Strategy 7
Strengths:
+ Food Justice of Geneva NY, Inc. is a grass roots effort with good community buy-in.

Challenges:
- Sustainability and willingness of community members to continue to volunteer.

8. Provide means for residents of Food Desert to obtain fresh fruits and vegetables and other healthy foods (Added 11/9/17). In 2018, RTS installed literature racks on buses to give OCHC partners opportunity to provide educational materials to riders.

   Partners
   - Food Justice of Geneva NY, Inc.
   - Regional Transit System
   - OCHC member organizations

   Process Measure: Number of grocery only bus routes
   1. OFA Shopper Service
   2. Wegmans Shopper Service
   3. Geneva Food Shopper Service-Two/week until quarter two when it was decreased to one/week (due to lack of ridership)

Strategy 8
Strengths:
- \+ Partnering with RTS removes the barrier of lack of transportation from acquiring healthy foods.
- \+ Partnering with RTS helps reach individuals of low SES with health messaging.

Challenges:
- − Sustainability is dependent on ridership.

DATA related to progress toward Overarching Objectives

Overarching Objective A: By December 31, 2018, reduce the percentage of children who are obese by 5% from 13.1% (2010) to 12.4% among WIC children (ages 2-4 years). (Data Source: NYS Pediatric and Pregnancy Nutrition Surveillance System [PedNSS])
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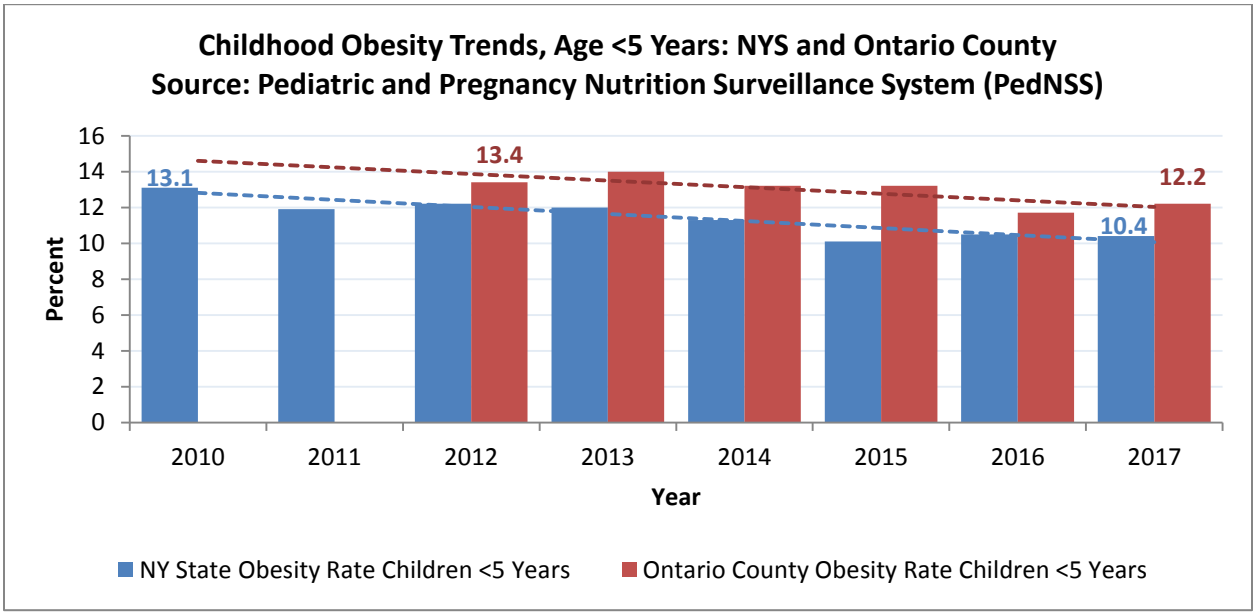
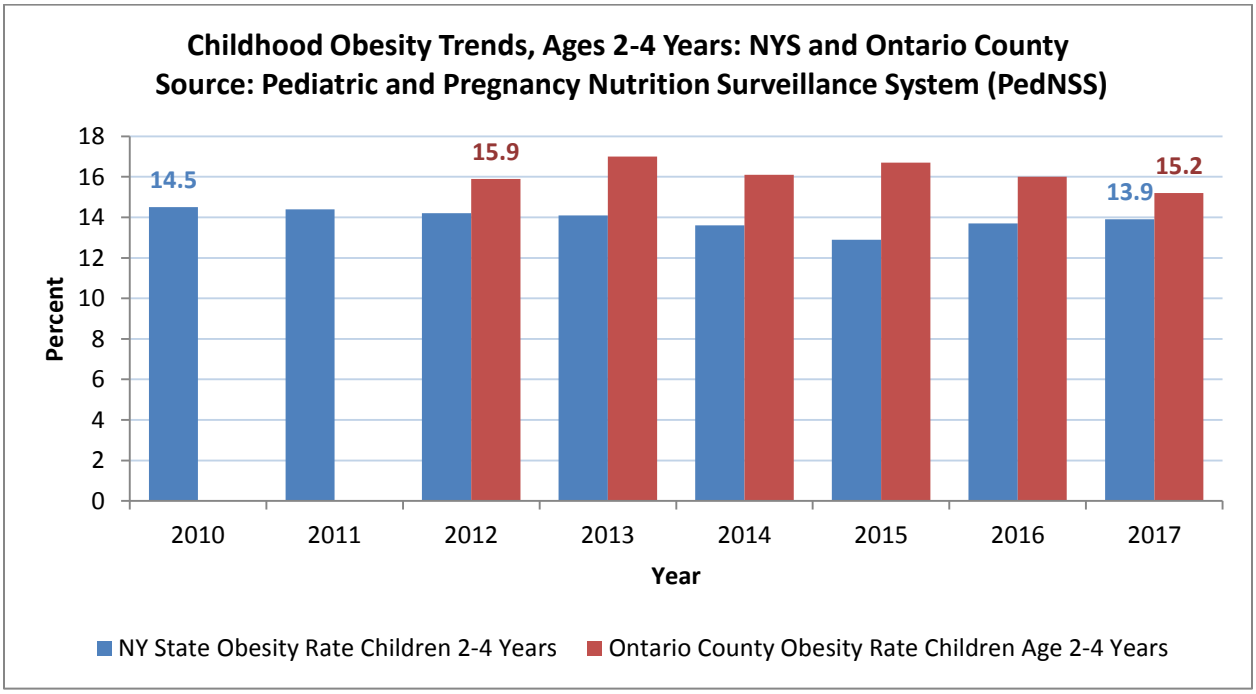


NY State: 20.6% decrease
Ontario County for years 2012-2017: 8.9% decrease



NY State: 4.1% decrease
Ontario County 2012-2017: 4.4% decrease

Discussion:

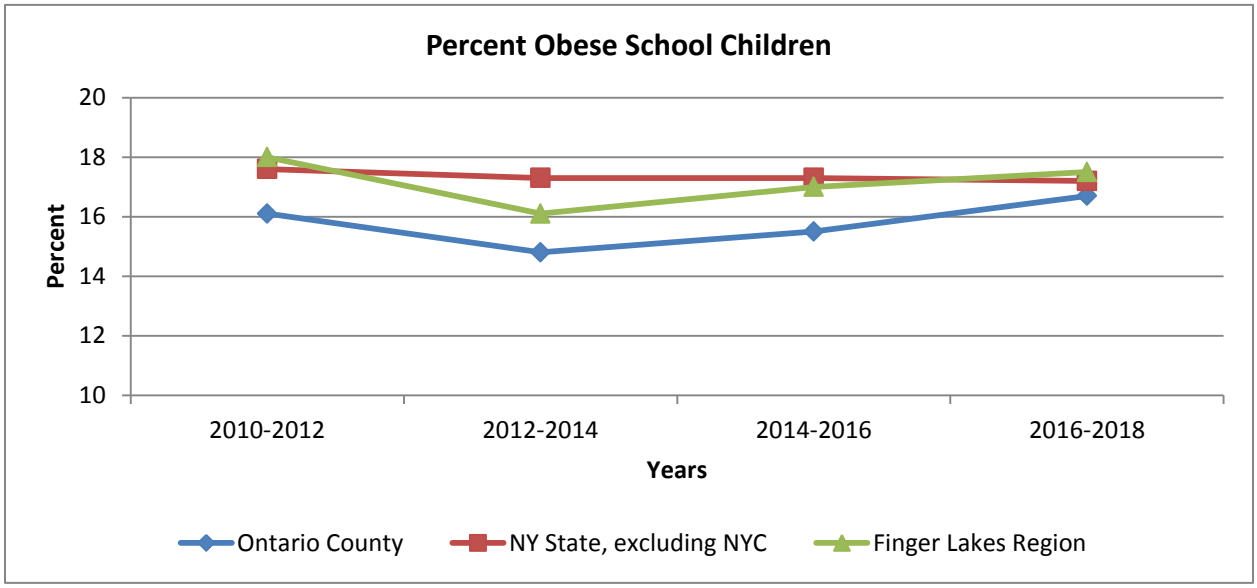
- More significant decrease in obesity in <5 year old population may indicate larger improvement in obesity from birth to 1 year and 364 days than in children ages 2-4 years.

- A 4% decrease in obesity in the 2-4 year age group is one percentage point short of goal set in 2016. Data from 2018 is not yet available.

Overarching Objective B: By December 31, 2018, reduce the percentage of children who are obese by 5% from 17.6% (2010-12) to 16.7% among public school children Statewide reported to the Student Weight Status Category Reporting system. (Data Source: NYS Student Weight Status Category Reporting [SWSCR]) (Prevention Agenda [PA] Tracking Indicator)

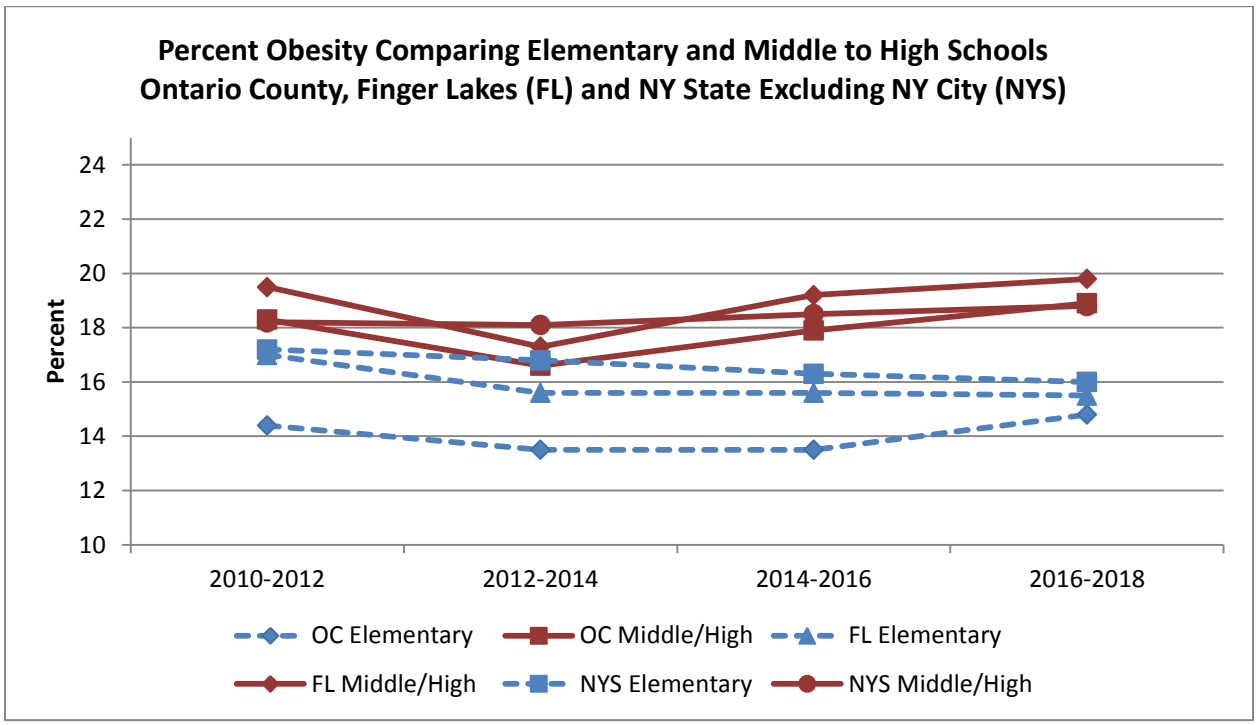
Percent Obesity-Public School Children

- NY State 2010-2012=17.6%
- NY State 2016-2018=16.5%
- Ontario County2010-2012=16.1%
- Ontario County 2016-2018= 16.7 %



Discussion:

- Increase in OC is concerning as State and Region have noted decreases
- NYS percent obese public school children; 6.3% decrease(2010-2018) – State PA Goal met
- Ontario County percent obese public school children; 3.7% increase (2010-2018)
- Finger Lakes Region percent obese public school children; 2.7% decrease(2010-2018)


Percent Obesity Comparing Elementary and Middle to High Schools
Ontario County, Finger Lakes (FL) and NY State Excluding NY City (NYS)
Percent
24
22
20
18
16
14
12
10
2010-2012
2012-2014
2014-2016
2016-2018
OC Elementary
OC Middle/High
FL Elementary
FL Middle/High
NYS Elementary
NYS Middle/High

PRIORITY AREA: PREVENT CHRONIC DISEASE

FOCUS AREA 1: REDUCE OBESITY IN CHILDREN AND ADULTS

GOAL 1.3 EXPAND THE ROLE OF HEALTHCARE, HEALTH SERVICES PROVIDERS AND INSURERS IN OBESITY PREVENTION

Overarching Objective 1.3.2

By 12/31/18, increase the percentage of infants born in NYS hospitals who are exclusively breastfed during the birth hospitalization by 10% from 43.7% (2010) to 48.1%.

Data Source: Bureau of Biometrics and Biostatistics, NYSDOH; NYC Office of Vital Records, NYC DOHMH)

RESULTS

Breastfeeding Exclusivity		
	2010	2013-2015
NYS	43.7%	43.1% (1.4% decrease)
Ontario County	65.6 %	63.3% (3.5% decrease)
2017 rates due out in July 2019		

Source: 2013-2015 NYS Pediatric Nutrition Surveillance System Data as of May, 2017

Though Ontario County saw a slight decrease in breastfeeding exclusivity between 2010 and 2015, the County exceeds the NYS goal of 48.1%, by a considerable margin.

Interventions, Strategies and Activities

1. Recruit hospitals to participate in quality improvement efforts to increase breastfeeding exclusivity at discharge.
2. Encourage and recruit pediatricians, obstetricians and gynecologists, Federally Qualified Health Centers (FQHCs), and other primary care provider practices and clinical offices to become New York State *Breastfeeding Friendly Practices.* Specifically target FQHCs first, to reach low income population (disparity).
3. Encourage and recruit Child and Adult Care Food Program (CACFP) participating daycare centers/homes to become New York State Breastfeeding Friendly Certified.
4. Identify location for a second Baby Café.

Partners and Roles

- UR Thompson Health: participate in quality improvement efforts to increase breastfeeding exclusivity at discharge and encourage affiliated practices to become BF Friendly Certified.
- Rochester Regional Health (CSHC): encourage affiliated practices to become BF Friendly Certified.
- Finger Lakes Community Health (FLCH): encourage affiliated practices to become BF Friendly Certified.

- Finger Lakes Health (FLH) to provide breastfeeding educational materials at affiliated family doctor's offices
- Ontario County Public Health and S2AY Rural Health Network: provide training, education, and assistance to practices and daycare centers/homes to become BF Friendly Certified.
- Finger Lakes Breastfeeding Partnership: participate in quality improvement efforts to increase breastfeeding exclusivity at discharge and provide training, education, and assistance to practices and daycare centers/homes to become BF Friendly Certified.
- WIC: provide breastfeeding data for Ontario County clinics
- Child and Family Services: assist with location for Baby Cafe

Process Measures

1. Number of breastfeeding classes offered in community
   - 12
2. Data from breastfeeding classes
   - 147 individuals took breastfeeding classes in 2018 at UR Thompson
3. Number of primary care practices that are designated as NYS Breastfeeding Friendly: 0
4. Number of women reached by policies and practices to support breastfeeding
   - Births at UR: 1,010
   - Thompson BF Classes : 12 Classes, 147 participants
   - Baby Café: 49
   - Maternal/Child Health Visits by OCPH: 31
5. Designated site for second Baby Café
   - Child and Family Resources in Geneva

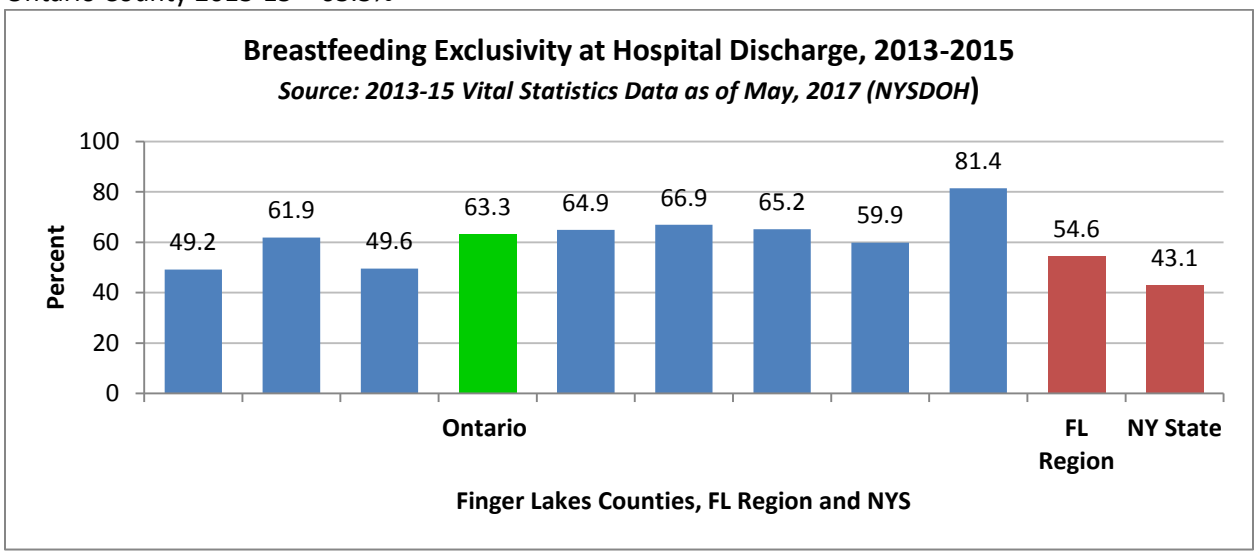
Strategies 1-4
Strengths:
+ Including the hospital, physician's offices and FQHC's guarantees low SES individuals are reached.
+ Baby Cafes are evidence-based.
+ Birthing Hospital partner offers classes, monthly.

Challenges:
- Providers have been slow to pursue Breastfeeding Friendly Status, despite having received education and resources.
- Difficult to track number of breastfeeding educational materials distributed by non-delivering hospitals.
- Anticipated funding was very late to arrive via the LIFT Grant.
- Sustainability of Baby Cafés is dependent on availability of Certified Lactation Counselors for staffing. The Breastfeeding Partnership has provided CLC training with some scholarships to ensure an adequate number of local CLC's.

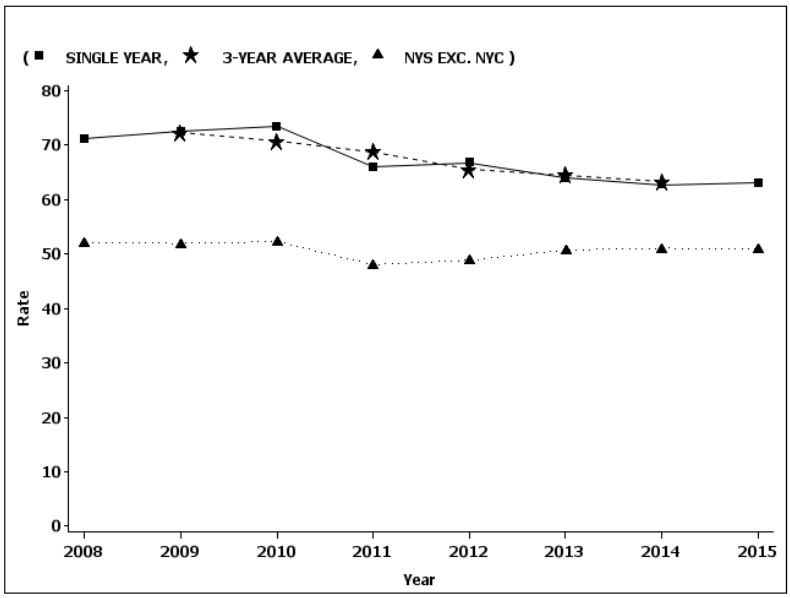
DATA related to Overarching Objectives

Overarching Objective: By 12/31/18, increase the percentage of infants born in NYS hospitals who are exclusively breastfed during **the birth hospitalization by 10% from 43.7% (2010) to 48.1%.**
Source: 2013-2015 Vital Statistics Data as of May, 2017 (most recent)

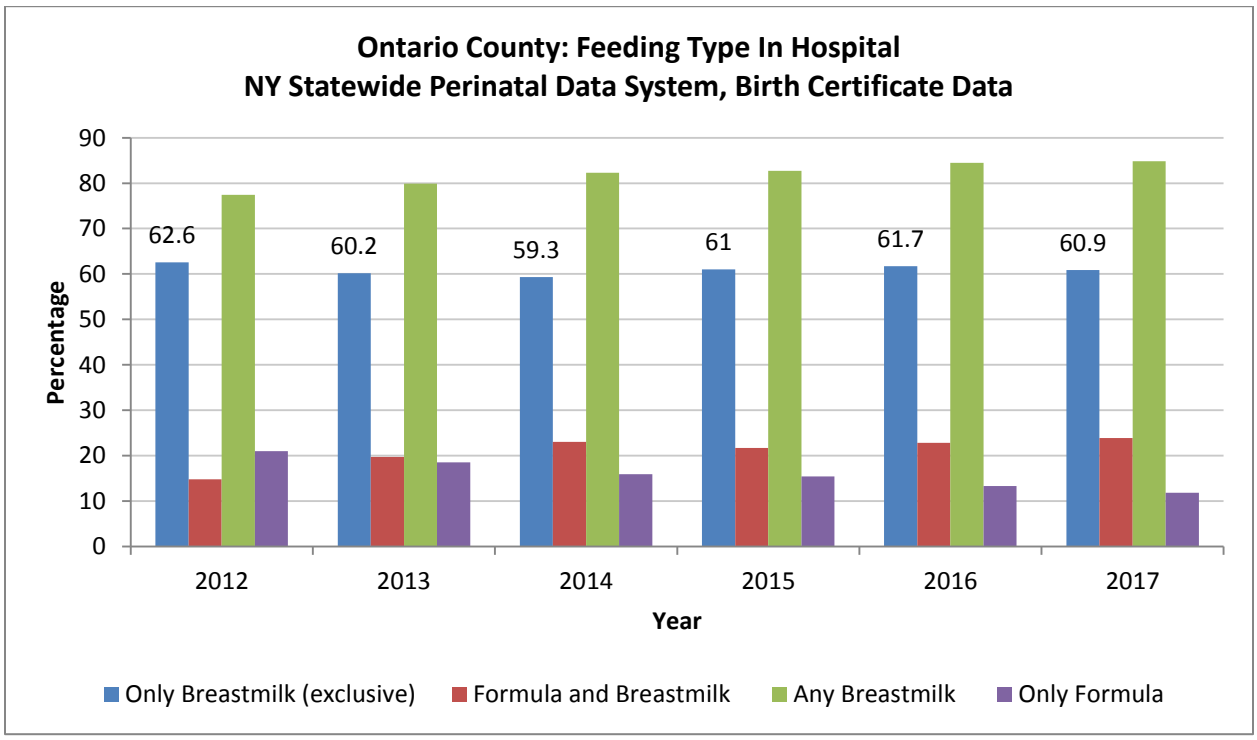
NYS 2013-2015 = 43.1% (decreased by 1.4%)
Ontario County 2013-15 = 63.3%



Ontario County Percentage of infants fed exclusively breast milk in delivery hospital



Source: 2013-2015 NYS Pediatric Nutrition Surveillance System Data as of May, 2017


Ontario County: Feeding Type In Hospital
NY Statewide Perinatal Data System, Birth Certificate Data
Percentage
90
80
70
60
50
40
30
20
10
0
62.6
60.2
59.3
61
61.7
60.9
2012
2013
2014
2015
2016
2017
Year
Only Breastmilk (exclusive)
Formula and Breastmilk
Any Breastmilk
Only Formula

PRIORITY AREA: PREVENT CHRONIC DISEASE

FOCUS AREA 1: REDUCE OBESITY IN CHILDREN AND ADULTS

GOAL 1.4 EXPAND THE ROLE OF HEALTHCARE, HEALTH SERVICES PROVIDERS AND INSURERS IN OBESITY PREVENTION

Overarching Objective 1.4.2
By December 31, 2018, increase the percentage of employers with supports for breastfeeding at the worksite by 10%.

Per NYS Prevention Agenda - Baseline to be determined.

Data Source: NYSDOH Healthy Heart Program Worksite Survey

Results: 5 Breastfeeding Friendly Childcare Centers in Ontario County

Interventions, Strategies and Activities

1. Use the *Business Case for Breastfeeding* to encourage employers to implement breastfeeding-friendly policies.

Partners and Roles

- UR Thompsons and Rochester Regional Health (CSHC) to work internally to implement breast feeding worksite strategies
- Finger Lakes Health to distribute Business Case for Breastfeeding and CLC referral materials to practices seeing new mothers.
- Ontario County Public Health and the S2AY rural Health Network: reach out to and provide support to worksites in adopting breastfeeding friendly policies.
- Regional Worksite Wellness: reach out to and provide support to worksites in adopting breastfeeding friendly policies.
- Finger Lakes Breastfeeding Partnership: reach out to and provide support to worksites in adopting breastfeeding friendly policies.

Process Measures

- Number of employers that have implemented lactation support programs.
    - 5 Childcare Centers
- Number and demographics of women reached by policies and practices to support breastfeeding.

Strategies 1-4
Strengths:
+ Using a regional approach provides consistency throughout the Finger Lakes.

Challenges:

- Breastfeeding Friendly Status for childcare providers required annual renewal. Once expired, many did not renew. The need for renewal has since been removed by the NYSDOH, so rates of participation should improve.
- Regional work on these strategies was stymied by the scope of the intervention (large number of businesses in the 8-county region), lack of stakeholder buy-in, and lag in receiving anticipated funding (LIFT Grant).

DATA related to Overarching Objectives

Overarching Objective: Increase the percentage of employers with supports for breastfeeding at the worksite by 10%.

Baseline to be determined

Data Source: NYSDOH Healthy Heart Program Worksite Survey-cannot locate
(Also, see: Focus Area – Maternal and Infant Health)

Breastfeeding Friendly Child Care (NYSDOH)
https://www.health.ny.gov/prevention/nutrition/cacfp/breastfeedingspon.htm

Number of trainings held for Childcare Centers: 10

FINGER LAKES COMMUNITY COLLEGE ASSOCIATION INC	CANANDAIGUA
GENEVA AGRI-BUSINESS CHILD DEVELOPMENT	GENEVA
GENEVA LAKEFRONT CHILD CARE CTR	GENEVA
KIMBERLY S BANCROFT	CANANDAIGUA
NICHOL M WILLIAMS	CANANDAIGUA

PRIORITY AREA: PREVENT CHRONIC DISEASE

FOCUS AREA 2: REDUCE ILLNESS, DISABILITY AND DEATH RELATED TO TOBACCO USE AND SECONDHAND SMOKE EXPOSURE

GOAL 2.1 PREVENT INITIATION OF TOBACCO USE BY YOUTH AND YOUNG ADULTS, ESPECIALLY AMONG LOW SOCIOECONOMIC STATUS (SES) POPULATIONS.

Overarching Objective 2.1.3
By December 31, 2018, increase the number of municipalities that restrict tobacco marketing (including banning store displays, limiting the density of tobacco vendors and their proximity to schools) from zero (2011) to 10. (Data Source: Community Activity Tracking, CAT)

RESULTS-NYS reached its goal

- 2011:0 municipalities
- 2019: 14 (New York State)

Partners and Roles

- Tobacco Action Coalition of the Finger Lakes (TACFL) to provide programming, outreach to elected officials, attendance at public hearings, and education/media outreach.
- OCHC – led by PH, to provide support through promotion and networking.

Interventions, Strategies, Activities

Encourage municipalities to implement policies that protect youth from tobacco marketing in the retail environment, also known as the point-of-sale (POS).

Process Measures

1. Number of municipalities that restrict tobacco marketing in stores, including:
    - Tobacco display restrictions: 0
    - Prohibiting the use of coupons and multi-pack discounts: 0
2. Number of elected officials communicated with about the impact of retail tobacco marketing on youth: 13
3. Number of public hearings attended. Number of organizations/key community leaders engaged in efforts: 2
4. Information, advertisements, and media utilized to educate and promote efforts: 12 (monthly press releases to the media)

Strengths:

+ TACFL is an experienced partner accustomed to working with legislators.
+ The Ontario County Legislative Body was willing to hold a public hearing related to raising the age of tobacco purchase to 21.

Challenges:

− The Ontario County Legislative Body voted down a proposed local law to raise the age of tobacco purchase to 21 years.

Changing Priorities
In early 2019, the Governor announced that raising the age of tobacco purchase and restricting advertising to youth will be attached to the passage of the NYS Budget. Additionally, the legalization of recreational cannabis is likely in 2019. Strategies to address these changing priorities will need to be developed. Partners' roles may change and new partners may be required. At this writing, the future of our work on Goal 2.1.3 is unknown.

Emerging Issue
The emerging issue of vaping, particularly among adolescents, will lead to changes in priorities and programming in 2019.

PRIORITY AREA: PREVENT CHRONIC DISEASE

FOCUS AREA 3: INCREASE ACCESS TO HIGH QUALITY CHRONIC DISEASE PREVENTATIVE CARE AND MANAGEMENT IN BOTH CLINICAL AND COMMUNITY

GOAL 3.2: PROMOTE USE OF EVIDENCE-BASED CARE TO MANAGE CHRONIC DISEASES

OUTCOME OBJECTIVE 3.2.4

By December 31, 2018, increase the percentage of health plan members, ages 18-85 years, with hypertension who have controlled their blood pressure (below 140/90)

RESULTS

- Controlled HTN 2015: 77%
- Controlled HTN 2017: 79%

Partners and Roles

- Common Ground Health: collect BP data; provide programming, reports and technical assistance to practices and partners
- Ontario County Public Health and S2AY RHN: provide assistance in recruiting practices to participate in registry and facilitate provider education
- Finger Lakes Health-provide data to Common Ground Health via electronic data transfer
- Rochester Regional Health (CSHC): provide data to Common Ground Health via electronic data transfer
- UR Thompson Health: provide data to Common Ground Health via electronic data transfer

Interventions, Strategies, Activities

1. Participation in regional blood pressure registry

Process Measures

- Number of primary care practices that submit patient numbers to registry
  - 15 practices
  - 11,338 patient readings 2018 (2015=13,189; 2016=14,504; 2017=15,773)

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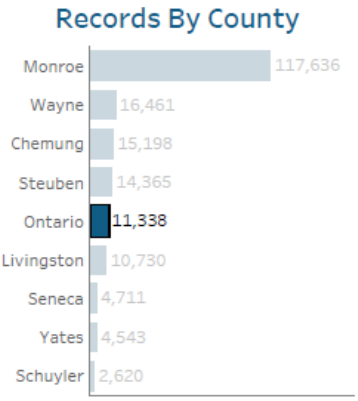
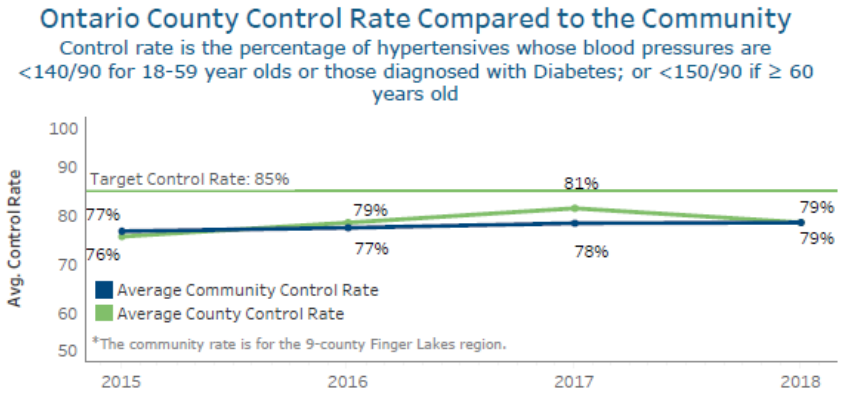
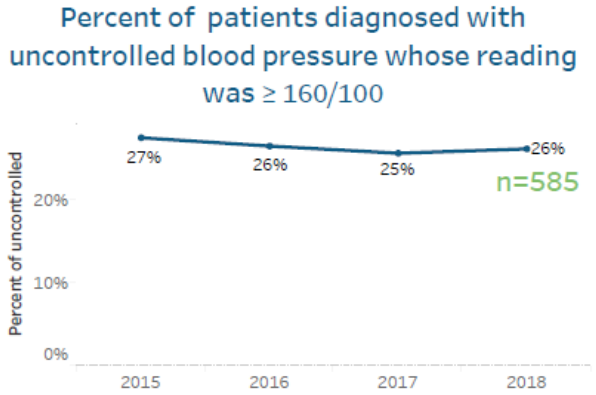
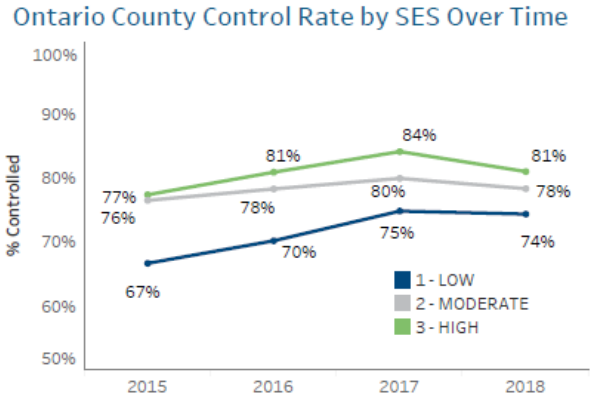








Source: Common Ground Health, June 2018 High Blood Pressure Registry Report: Ontario

Strengths:

+ Once in place, the registry requires very little effort on the part of participants.
+ Reporting out control rates cumulatively for a practice gives providers an indication of the effectiveness of their patient encounters.
+ Reporting out by region with identifiers removed, may create incentive to improve control rates via perceived competition.
+ Providing objective data in real time increases a practice's commitment to addressing the problem of poorly controlled hypertension, including attending educational events.

Challenges:

- In 2018, data was not reported by a large medical practice as it was in the process of becoming affiliated with a regional hospital and changing EMR vendors at the time of data upload.
- Training for medical providers was not well attended. A web-based training was offered to address this.

PRIORITY AREA: PREVENT CHRONIC DISEASE

FOCUS AREA 1: REDUCE OBESITY IN CHILDREN AND ADULTS

GOAL 3.3 Promote culturally relevant chronic disease self-management education.

PROMOTE THE USE OF EVIDENCE-BASED INTERVENTIONS TO PREVENT OR MANAGE CHRONIC DISEASES.

Overarching Objective 3.3.1

By December 31, 2018, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition.
Data Source: Bureau of Biometrics and Biostatistics, NYSDOH; NYC Office of Vital Records, NYC DOHMH

RESULTS

% Adults (with Chronic Condition) Who Took a Course to Learn how to Manage Their Condition.					
Source: BRFSS		Crude Rate (%)	Confidence Interval	Age Adjusted %	Confidence Interval
NYS, excluding NYC	2016	25.9	24.8-27	23.8 (66.4%↑)	22.8-24.9
	2013-14	8.6	7.8-9.5	8.0	7-9.1
Ontario County	2016	11.8	5.0-18.5	17.5 (43%↑)	5.5-29.4
	2013-14	10.8	6.2-18.0	10.0	5.3-18.1

Source: Bureau of Biometrics and Biostatistics, NYSDOH; NYC Office of Vital Records, NYC DOHMH

Progress appears promising with significant increases in NYS and Ontario County. Of concern, particularly for the County, are significantly large confidence ranges.

Interventions, Strategies and Activities

1. Conduct CDSMP in the community
2. Support CDSMP classes by assisting with training of Peer Leaders
3. Provide coordination of evidence based programs in the Finger Lakes Region
4. Assist provider offices to embed verbiage re weight, diet, and exercise into EMR's with automatic electronic referral to EBI's.
5. Conduct NDPP in the community

Partners and Roles

- UR Thompson Health and Wayne CAP will offer, conduct and promote CDSMP classes in the community. Wayne CAP removed from partner list in 2017.
- Public Health to coordinate training for additional CDSMP Peer Leaders and fill in as needed.

- OCHC to identify additional partners that can be trained in CDSMP, promote classes and support as a county wide initiative.
- S2AY RHN / Regional Living Healthy Group to assist with coordination of evidence based programs and provide back-up peer leaders for classes.
- 5/11/17 Addendum: FLH to offer NDPP for community members via its Diabetes Center.

Process Measures

1. [Percent of adults with one or more chronic diseases who have attended a self-management program.] 12/2017-Process measure changed to: Track the number of adults with one or more chronic diseases who have attended a self-management program.
    a. 49 completed CDSMP
    b. 24 completed NDPP
2. Number of providers that use their EHRs to trigger them to speak to their patients about their weight, diet and exercise, and refer them to EBI: 0. The grant (via the S2AY RHN) with which this was going to be accomplished was not received.

Strengths:

+ CDSMP and NDPP are evidence-based and relatively easy to administer
+ Hospitals are willing to sponsor classes. Community perceives both hospitals as trusted sources of information and hospitals have ability to plan, advertise and hold classes on or off-site.
+ CDSMP at jail provides this service in a high risk community that is often difficult to reach.

Challenges:

- Slow uptake from the medical community. Continue to work on marketing and awareness.
- Inability to work with providers on changes to their EMR's due to lack of funding.
- Insufficient number of trained Peer Leaders. This challenge has been addressed by both UR Thompson (obtained master trainer status) and OCPH (sent two staff members for Peer Leader training).
- Wayne Cap stopped participating in OCHC.

PRIORITY AREA: PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE

FOCUS AREA 2: PREVENT SUBSTANCE ABUSE AND OTHER MENTAL EMOTIONAL BEHAVIORAL DISORDERS

GOAL 2.1 Prevent underage drinking, non-medical use of prescription pain relievers by youth, and excessive alcohol consumption by adults.

Overarching Objective 2.1.2

By December 31, 2018, reduce the percentage of youth ages 12-17 years reporting the use of non-medical use of painkillers. (Baseline: 5.26% 2009-2010, NSDUH, Target: 4.73%) - https://www.samhsa.gov/data/sites/default/files/NSDUH115/NSDUH115/sr115-nonmedical-use-pain-relievers.htm

RESULTS

% New York 12-17 Year-olds Reporting the Use of Non-medical Painkillers	
2009-10	2010-11
5.26%	4.70%

Source: SAMHSA NSDU Report Jan, 2013

Encouraging 10.6% decline in percent of adolescents reporting use of non-medical pain killers.

Interventions, Strategies and Activities

Implement strategies to prevent overdose including

1. Engage the community and build a coalition (Ontario County Substance Abuse Coalition-OCSAPC)
2. Educate prescribers
3. Reduce supply through “lock your meds” campaigns, placing prescription drop boxes, and facilitating drug take back days
4. Provide harm reduction through Narcan trainings
5. Provide community based prevention education
6. Evaluate project components/success

Partners and Roles

- Substance Abuse Prevention Coalition of the Partnership for Ontario County will:
  - Provide programming, trainings and educational sessions in the community
  - Facilitate monthly meetings of the SAPC and engage key community stakeholders
  - Work with law enforcement to place drop boxes in the community and to host drug (unwanted medication) take back days

- OCPH, RRH/CSHC, FLH, URTH, Ontario County Mental Health (OCMH), OCHC, and law enforcement to provide support through promotion, networking, and sending staff to trainings (NARCAN, Mental Health First Aid, etc.).
- RRH/CSHC houses a psyche unit and provides in/outpatient services and case management for psyche and substance abuse.
- OCPH, FLH, URTH, and RRH/CSHC to provide NARCAN trainings and/or education.

Process Measures

- Number of members engaged in OCSAPC
  - 28 active; 64 additional who receive minutes, attend work groups, volunteer or assist in other ways.
- Number of schools and student participants
  - 9 schools; 1,205 students
- Number of trainings held for prescribers = 0
- Number of medication drop boxes placed and number of drug take-back events
  - 23 drop boxes placed in the County (3,393 pounds collected)
  - UR Thompson Health collected 676 pounds via the box in their lobby
  - 3 medication take back events held in the community
- Number of educational trainings, workshops, and forums held (number of participants)
  - 67 events held by the SAPC of Ontario County; 1,195 residents reached
- Number of Narcan Trainings
  - 12 Narcan trainings were held; 200 individuals trained

Strategies 1-6
Strengths:

+ The SAPC quickly became an active, effective partner. Their Director engaged with OCHC, gained the trust of schools and became a conduit between OCHC members and school leadership.
+ Engaging schools provided large audiences and addressed the SES disparity (children of all SES's were reached)
+ NYSDOH provided Narcan to OCPH at no charge for distribution in the community (coupled with education). Uptake was good and community awareness of addiction as an illness was raised.
+ Take back events collected hundreds of pounds of medication and provided "visuals" of law enforcement as partners in resolving the opioid epidemic.
+ As a Narcan distributor, OCPH's relationships with law enforcement and first responders matured.
+ Making medication drop boxes commonplace removed unwanted medications from circulation quickly and raised community awareness re addiction prevention.

Challenges:

- Difficult to engage prescribers in coalition work or in trainings.
- Grant that supported the SAPC came to a close.

PRIORITY AREA: PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE

FOCUS AREA 2: PREVENT SUBSTANCE ABUSE AND OTHER MENTAL EMOTIONAL BEHAVIORAL DISORDERS

GOAL 2.3.2 Prevent Suicides among youth and adults

Overarching Objective: By December 31, 2018, reduce the age-adjusted suicide mortality rate by 10% to 5.9 per 100,000. (Baseline: 6.6 per 100,000, Bureau of Biometrics 2007-2009)

https://www.health.ny.gov/statistics/prevention/injury_prevention/docs/selfinflicted_all.pdf

RESULTS

Goals for suicide rate decrease were not met.

Data from https://www.health.ny.gov/statistics/prevention/injury_prevention/docs/selfinflicted_all.pdf shows suicide death rate in all of NYS at 8.2/100,000 in 2014 (most recently reported year). This is an increase from 2009.

Additional data show an increase per 100,000, statewide (https://nyshc.health.ny.gov/web/nyapd/suicides-in-new-york):

Suicide Deaths, Rate per 100,000: NYS and Ontario County, 2014-2016			
	NY State	NYS, excluding NYC	Ontario County
2014	8.4	10	
2015	8.2	10.2	
2016	8.5	10.3	
Avg. of 3 Years	8.4	10.2	14.6*

Source: NYSDOH, Suicide and Self-harm

*Will need to use new baseline of 14.6/100,000 in future CHIP's and create local goal(s) for reduction in addition to statewide goal.

Interventions, Strategies and Activities

1. Implement proven suicide prevention practices including screening for risk, pathways to care, interventions that are effective against suicide and follow-up after acute treatment Advocate for MEB disorder screening of individuals at risk in primary care settings. Identify and strengthen opportunities for sharing data on access to care, identifying service gaps, studying cost-effectiveness strategies for integration and coordination, and the impact of interventions.

Partners and Roles

Ontario County Suicide Prevention Coalition: Provide leadership and expertise to physician offices. Subcommittee to work with provider offices to determine feasibility of including additional fields related to suicidal ideation and referral in EHRs.

Process Measures

1. # of providers using EHRs that include prompts for documentation of discussion of suicidal ideation and provision of referral services.

The Ontario County Suicide Prevention Coalition subcommittee provided tool kits to all medical provider offices in the County encouraging the use of EHRs to prompt discussion of suicidal ideations and to provide referrals. Included in tool kits was information about referral to mental health services in the County. It is unknown at this time how many providers are using EHRs to address this issue.

Additional Data on Suicide from the NY State DOH at
https://www.health.ny.gov/statistics/prevention/injury_prevention/docs/selfinflicted_all.pdf

Strengths:

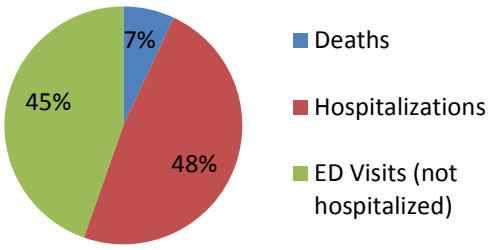
+ Suicide Prevention Coalition subcommittee created a comprehensive tool kit for providers to assist with querying patients about mental health/suicidal ideations with provisions for rapid referral.

Challenges:

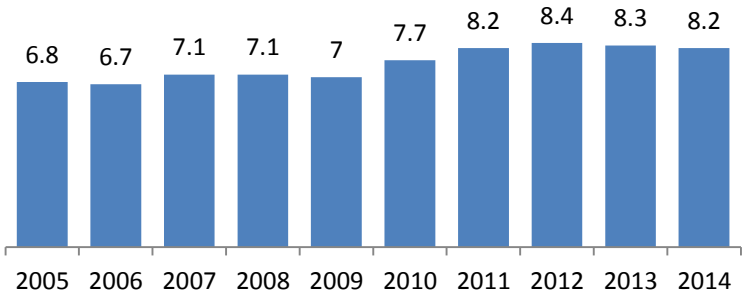
- Suicide data used to assess progress at the state level are 2 years old.
- Tracking suicides at the local level is difficult.
- Medical providers were approached but were difficult to engage. It has not been possible to measure the effect of these efforts.

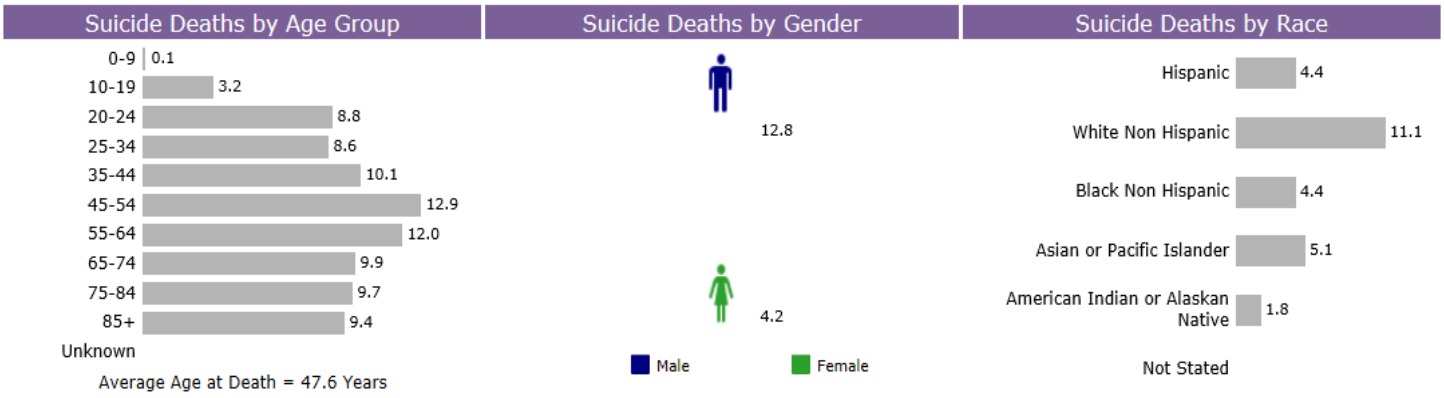
Data Related to Overarching Objectives

NY State Suicide Data, 2005-2014
N=211,806



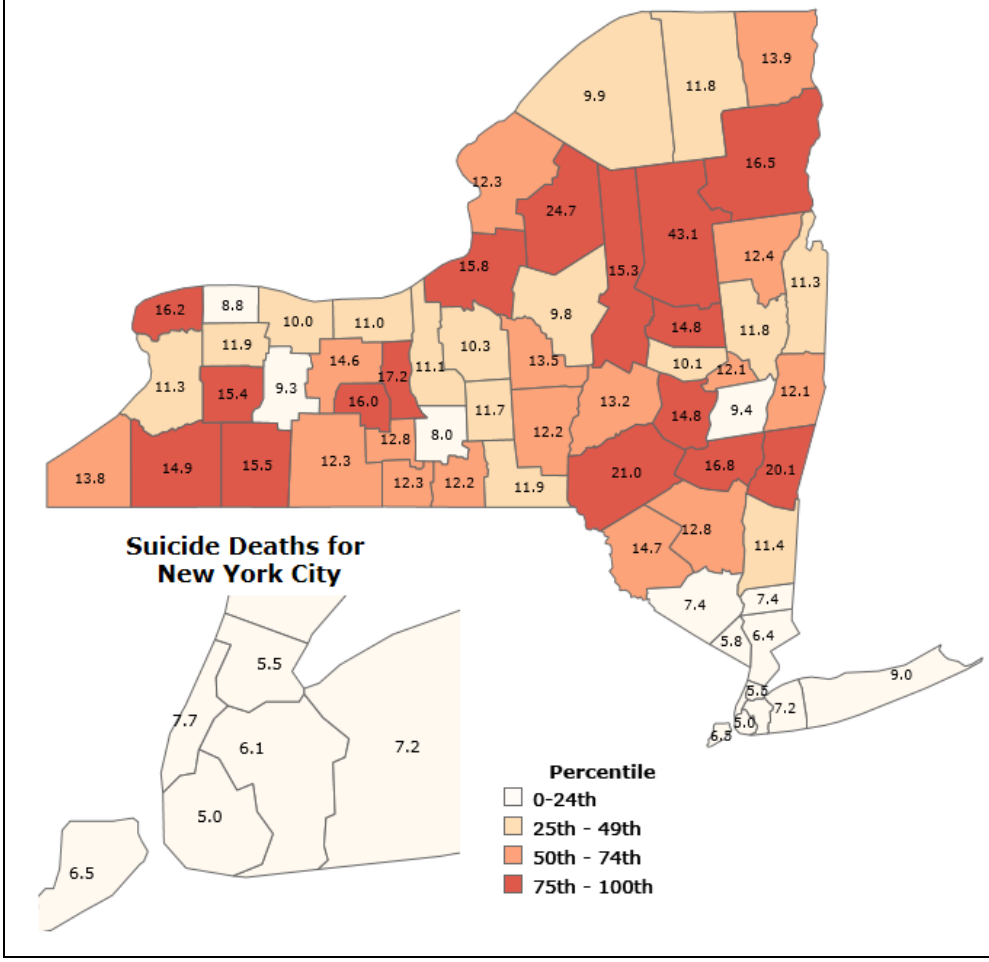
NY State Suicide Deaths, 2005-2014
Rate per 100,000





Death Rate per 100,000 Population				% Change from 2015 to 2016
	2014	2015	2016	
New York City	6.3	5.7	6.1	▲7.2%
Rest of State	10.0	10.2	10.3	▲1.1%
Statewide	8.4	8.2	8.5	▲2.8%

Suicide Deaths per 100,000 in New York, 2014-2016
Source: NYS Health Connector, Suicide and Self Harm



Source: NY State Health Connector, Suicide and Self Harm at https://nyshc.health.ny.gov/web/nyapd/suicides-in-new-york)

PRIORITY AREA: PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE

FOCUS AREA 3: STRENGTHEN INFRASTRUCTURE ACROSS SYSTEMS

GOAL 3.1 Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment and recovery

Overarching Objective: Per NYS PA, TBD.

County specific outcome objectives:

1. By 12/31/18 have a well-established Suicide Prevention Coalition with stakeholders from a variety of disciplines.
2. By 12/31/18, establish at least one mobile Syringe Exchange Program (SEP) in Ontario County.

As a County we reached both of these objectives in 2018.

RESULTS

1. Suicide Prevention Coalition established with stakeholders from a variety of disciplines in 2018
2. Mobile SEP began in 3/2018 at one Ontario County location. A second SEP was added mid-year.

Interventions, Strategies and Activities

1. Identify and strengthen opportunities for sharing data on access to care, identifying service gaps, studying cost-effectiveness strategies for integration and coordination, and the impact of interventions.

2. Partner with existing provider of Syringe Exchange Program (SEP) in Monroe County (Trillium Health) re feasibility of providing a mobile SEP in Ontario County. Facilitate establishment of mobile SEP by:

- Educating and engaging community members, leaders and law enforcement re harm reduction and SEP
- Identifying two sites in Ontario County for SEP
- Supporting Trillium as they begin SEP services in Ontario County

Partners and Roles

1. Suicide Prevention Coalition
   - Ontario County PH-assist with creation of Suicide Prevention Coalition
   - Ontario County Mental Health-offer expertise to Suicide Prevention Coalition
   - Partnership for Ontario County-Provide leadership for OC Suicide Prevention Coalition
   - Participants in Ontario County Suicide Prevention Coalition:
     - Mental Health
     - Ontario County PH
     - Partnership for OC
     - Office for the Aging
     - Schools and colleges
     - Medical providers
     - City government
     - Law enforcement
     - Hospitals & FQHC's
     - Faith based
     - Coroner
     - Community members

2. Mobile Syringe Exchange Program (SEP)
    - Ontario County PH-educate community, stakeholders and legislators about SEP. Determine community readiness.
    - Trillium Health-provide SEP service
    - FLACRA-provide a site for SEP service
    - Law enforcement-support SEP service
    - Canandaigua Fire House-provide a site for SEP service
    - OCHC-provide network to get messages to community and other stakeholders about the importance of harm reduction and value of SEPs.
    - Elected officials/policy makers- provide leadership to community re value of risk reduction and positive impact of SEPs on lives of addicts.

Process Measures

1. Development of a County-wide Suicide Prevention Coalition
    a. # of stakeholders engaged = 127
    b. Coalition meets every other month with subcommittees meeting on alternate months
2. Mobile SEP
    a. # policy makers and law enforcement educated/informed = 6 Ontario County Supervisors at Health and Human Services Committee; City leadership in Canandaigua and Geneva; Law Enforcement from County (Sheriff) and Cities (6 total)
    b. SEP sites established: 2
    c. # of participants: 4 clients, 6 encounters 3/2018-10/2018

Strategy 1
Strengths:
+ Community interest. The SPC is represented by a variety of disciplines and has been active.
+ Funds were available to bring a nationally known speaker to a community forum.
+ Public Health staff and Mental Health staff have been trained to deliver suicide prevention programming.
+ Public Health and Mental Health have collaborated across disciplines.

Challenges:
− Response to the creation of the SPC was robust. Because of the number of participants and the variety of disciplines they represented, it took time to organize and establish an identity. Once group goals were developed, the formation of subcommittees was key to carrying out the work of the coalition.

Strategy 2
Strengths:
+ Quick buy-in from community leaders re need for SEP.
+ Permission to open 2 sites was relatively easy to achieve.
+ Cooperation across disciplines (PH, law enforcement, local legislators, fire department, FLACRA, Trillium)

Challenges:
− SEP's have been underutilized
− Barriers to their use have not been clearly identified